Extended Follow-up

The extended follow-up consists of at least one (1) direct contact with the beneficiary and a family member or provider to re-evaluate the individual service plan due to changes in the beneficiary's personal or family factors.

The extended follow-up will require additional documentation if billed more than three (3) times during a calendar year. If subsequent visits are billed, documentation of necessity of the service must be attached to each claim. The Department will either approve or deny the claim.

Only one (1) brief or one (1) extended follow-up may be billed each month with a maximum of twelve (12) follow-up services per year.

Dates of service for case management follow-up must occur after the initial assessment.

In the event of multiple types of targeted case management, only one type will be reimbursed during the calendar month for each beneficiary.

TRANSMITTAL 93-04
APPROVED 1/11/95
EFFECTIVE 3/01/93
SUPERSEDES NEW

STATE: Georgia

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N. (h) Perinatal Case Management Services/Area C will be billed monthly on the HCFA 1500 form and be reimbursed on a prospective fee-for-service basis. Payments to public and private providers are limited to the lesser of the submitted charge or the established fees based on the actual cost of public providers as determined by time studies conducted pursuant to methodology approved by HCFA, Region IV. Costs will be evaluated annually and fees adjusted to reflect actual cost.

PREGNANT WOMAN, COMPREHENSIVE ASSESSMENT: Service to a newly pregnant woman whose case management records must be established. This service will be completed within 30 days of enrollment into case management services. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, educational, social, psychological, and other needs of each pregnant woman. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Pregnant women will be referred to a prenatal care provider.

2. Pregnant women will be referred to the County Department of Health for nutritional assessment and for WIC benefits.

3. Arrangements will be made for any necessary transportation to prenatal care appointments.

This unit of service will be billed once for each eligible pregnant woman.

NEWBORN, COMPREHENSIVE ASSESSMENT: Service to a newborn whose case management records must be established. This service will be completed within 30 days of birth. A comprehensive level of service will be provided including an assessment and individualized service plan for the health, social, psychological, and other needs of each newborn. A problem list will be developed based upon the comprehensive assessment and service priorities established. Initial linkages will be made with providers of the needed identified services for at least the top three priorities. For example:

1. Newborns will be referred to an EPSDT provider for EPSDT services.

2. Newborns will be referred to the County Department of Health for nutritional assessment and for WIC benefits.

3. A referral will be made to the County Department of Family and Children Services to assist newborns living in abusive family situations.

This unit of service will be billed one for each eligible newborn.

TRANSMITTAL 93-020
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

STATE: Georgia

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

CASE MANAGEMENT FOLLOW-UP: Services to an established service recipient. All contacts with the recipient and/or recipient's family by Case Management personnel must be documented by level of services to receive reimbursement. Reimbursement is limited to a maximum of 12 visits annually. Dates of service must occur after the comprehensive assessment.

The level of service billed will be based on the service recipient's individual service plan and the need for case management assistance as defined below.

Brief Follow-up: Consist of at least one (1) minimal contact with the recipient, the family or the service provider to ensure that the recipient is complying the established service delivery plan.

Extended Follow-up: Consist of a minimum of one direct contact with the recipient and the family to reevaluate or reassess the individual service delivery plans due to changes in recipient's personal or family factors.

TRANSMITTAL 93-020
APPROVED 5-4-94
EFFECTIVE 4-1-93
SUPERSEDES NEW

Policy and Methods for Establishing Payment Rates For Other Types of Care or Services

N.(i) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. However, if a family has more than one child in the home with the parent and no children have been placed outside of the home, the Department will only reimburse for one child within the family unit. Services will be reimbursed only for eligible recipients.

A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services.

TRANSMITTAL 93-40
APPROVED 5/27/94
EFFECTIVE 7/1/93
SUPERSEDES new

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

N.(j) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Random Moment Sample Study. Rates will be adjusted annually based on the results of the previous four quarters. The Random Moment Sample Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation.

A maximum of one unit of case management services will be reimbursed per month for each eligible recipient. A unit of case management service is defined as at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be for the coordination or linkage of services for a specific recipient.

TRANSMITTAL 93-091
APPROVED 8/24/94
EFFECTIVE 7/01/93
SUPERSEDES New

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Rural Health Clinic Services

As established by 42 CFR 447.371, payment for clinic services will be based on a reasonable cost rate per visit as determined by Medicare. Other ambulatory services will be reimbursed at a rate for each service by the agency. Cost settlements will be made.

Effective for dates of service July 1, 1994, and after, a $2.00 recipient co-payment is required on all rural health clinic services. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not subject to the co-payment. Emergency services and family planning services are also exempt from a co-payment.

TRANSMITTAL 94-029
APPROVED 2-3-95
EFFECTIVE 7-1-94
SUPERSEDES NCW

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

Non-Emergency Transportation Services

Non-Emergency Transportation is reimbursed according to the following methods, depending on type of vehicle and number of passengers for exceptional travel or the number of Medicaid eligibles in a region. Upper reimbursement limits shall not exceed charges determined to be reasonable by the state.

(a) The broker is reimbursed a monthly capitated rate for each Medicaid recipient residing in the region.

(b) For exceptional travel, the Department of Family and Children Services is reimbursed a mileage rate per passenger for automobile services; commercial and public transportation are reimbursed at the usual and customary rate.

(c) $1.00 recipient co-payment is required on all modes of exceptional non-emergency transportation services. Pregnant women, recipients under 21 years of age, nursing home recipients, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are not subject to the co-payment. In addition, volunteer drivers, city transit and services supportive to transportation including meals, lodging, parking, tolls and others are not subject to the co-payment.

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

o. Ambulatory Surgical Center Services and Birthing Center Services

1. Reimbursement for surgical procedures performed in the center is limited to the ASC facility fee as determined by Medicare.

2. Reimbursement for the facility vaginal delivery fee will not exceed the amount that Medicare would reimburse. The facility fee payment for delivery services is made at the Group Four (4) ASC surgical reimbursement rate for the geographical area in which the billing facility is located. Rate adjustments are based on changes made in the ASC facility fee assigned for the group. The payments for related services provided by physicians or physician extenders are made under other Medicaid service programs.

3. Effective for dates of service July 1, 1994, and after, a $3.00 recipient co-payment is required on all ASC facility services. Pregnant women, recipients under twenty-one years of age, nursing home residents, and hospice care recipients are not required to pay the co-payment. Emergency services and family planning services are exempt from a co-payment.

TRANSMITTAL 94-059
APPROVED 12-3-95
EFFECTIVE 7-1-94
SUPERSEDES 90-037

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICE

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Hospice Services

The Department reimburses hospices for hospice services in accordance with hospice payment rates defined at Section 4306.3 of the State Medicaid Manual. The Department will continue the payment rates which were in effect on October 1, 1990, through the end of the calendar year. There will be no reduction as required by Section 4007 of the Omnibus Budget Reconciliation Act of 1990 applicable to the Medicare program. Payment for physicians' professional services is in accordance with the usual Georgia Medicaid reimbursement policy for physicians' services.

The Department pays an additional per diem amount for routine home care and continuous home care days for hospice care that is furnished to an individual living in a nursing facility. This additional amount is for "room and board" which includes performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medications, maintaining the cleanliness of a resident's room, and supervision therapies. This amount is 95% of the per diem that would have been paid to the nursing facility for that individual in that facility under the State Plan. This rate ~~is~~ in addition to the routine home rate or the continous home care rate. The hospice retains full responsibility of the professional management of the individual's hospice care and the nursing facility agrees to provide "room and board" to the individual.

TRANSMITTAL 90-46
APPROVED 8-15-91
EFFECTIVE 10-1-90
SUPERSEDES (NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE GEORGIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item Q. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount
Part A Coinsurance	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount
Part B Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s)_____.